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THE Hampden Hippocrat

JANUARY–FEBRUARY 1995

Lonnie R. Bristow, M.D., *President-Elect AMA*

AMA and Medicare Reform

The Hampden Hippocrat
1111 Elm Street
West Springfield, MA 01089

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HAMPDEN DISTRICT MEDICAL SOCIETY 1995-1996 SEASON

ANNUAL MEETING

PLACE: **CARRIAGE HOUSE**
Old Storrowton Tavern
West Springfield, MA

DATE: Tuesday, April 25, 1995 SPOUSES ARE WELCOME!

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m.

SPEAKER: State Representative Carmen H. Buell

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on April 25th. If the cancellation is not made, you will be BILLED for your dinner.

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I shall attend the meeting at STORROWTON TAVERN:

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I shall bring a guest (name) _____

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____ Baked Boston Scrod

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THE
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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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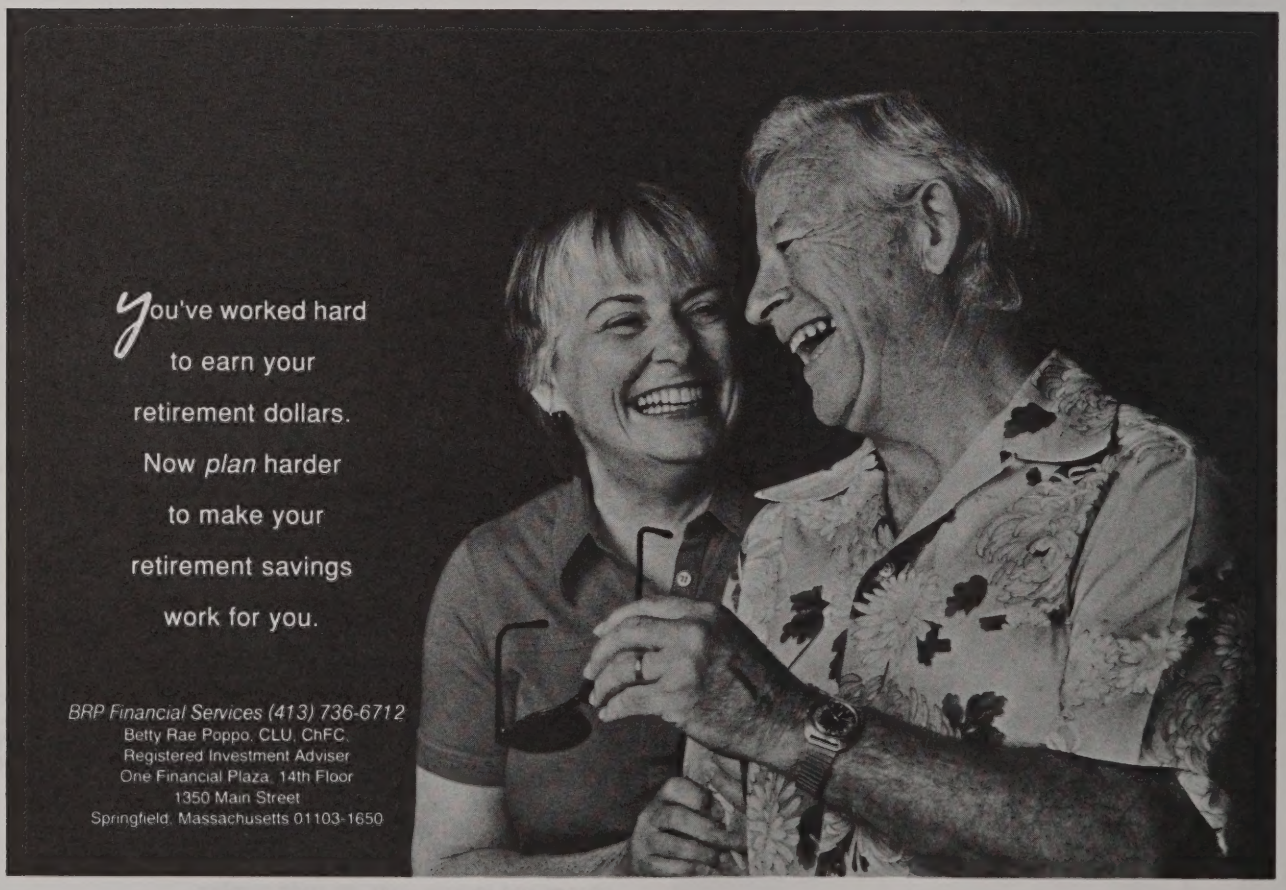
From The Editor

This mid-winter issue of the Hippocrat focuses on politics and health care. We have reports from Dr. Frank Horrigan and Dr. Alan Harvey on the fall meetings of the MMS and the AMA. We also have an address from AMA President Lonnie Bristow on the AMA's legislative agenda regarding Medicare.

We mark the passing of the Ludlow Hospital with a report on its life across the twentieth century. Professor Dyck's local address which gave an ethical critique of physician suicide is included. Those who wish to comment on these various contentious areas are encouraged to contact me directly or Carol at the District Office. Read on!

Brigid Glackin, M.D.
Editor



Hampden Committee Activities

The Public Health Committee was fortunate to have Dr. Stephen Gehlbach, Dean of the UMass School of Public Health, address its members at their December meeting. Discussion centered on future directions for public health in general. Dr. Gehlbach was impressed with the progress we have made on the non-smoking issue. He suggested we might try and get something going in reference to alcohol abuse. Dr. Gehlbach also stated that there are 200 graduate students enrolled in the Masters of Public Health Program at UMass. Perhaps they would assist our committee with a specific project. Dr. Gehlbach will take all the information reviewed at this meeting and try to incorporate it with one of their programs.

The Executive Committee met in November and December. Dr. Ross reported on the November 16th President's Dinner held at the new MMS Regional Office in Holyoke. Doctor Francis Van Houten, President of Mass Medical, reviewed some of the programs at state level. He discussed the MMS support of the publication of names of physicians whose staff privileges have been taken away. He also reviewed the Community Health Information Network (CHIN) and the status of any willing provider legislation.

Dr. Lonnie Bristow, President-Elect of the American Medical Association will speak at our Winter District Meeting on January 24, 1995 at the Sheraton-Springfield Monarch place. The New England Delegation of the AMA has been invited to attend.

Dr. Bernard Bloom submitted a report in regards to scholarships granted this year. Five students received outright scholarships of $1000 each from Hampden District Medical Society. Three students received scholarship loans from the Millman Foundation in the amount of $1000 each. ■

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- reducing estate taxes, and protecting assets from creditors' claims?
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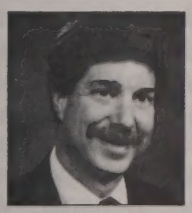

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Plainly Speaking

Life is so precious yet so short. Death is just a vague fact somewhere in the distant background, especially when one is young and healthy. Then suddenly a serious illness develops and you are face to face with death.

Alicia O. M. Ross, M.D., President

Recently, the 23-year-old son of a friend was diagnosed with a rare form of malignant lymphona called Burkitt's Lymphoma. This is a highly aggressive lymphoma which is more common in children and rare in adults. Straus et al reported that 59% of 28 patients tested very intensively with combination chemotherapy program were able to achieve long-term survival with no evidence of disease. However, there is a 14-18% relapse rate. At present, bone marrow transplantation appears to confer a better cure rate and long-term, disease-free survival for these patients. Preliminary reports suggest that bone marrow transplant is probably superior to chemotherapy. Ideally, the best match is obtained from a twin sibling. Obviously, the majority of us don't have one. The next best source is the rest of the patient's family members wherein there is a 30% chance of finding a match. When no matching sibling is available, one searches for unrelated donors. The odds of matching an unrelated donor varies from 1:100 to 1:1,000,000. Since these odds are so high, there is a great need to find as many volunteer donors as quickly as possible. More than 20,000 marrow transplants have been performed worldwide. The combined registries of the National Marrow Donor Program and the American Bone Marrow Donor Registry have about 1.5 million volunteer donors listed. These numbers are small relative to the number of donors needed to find a match. The percentage of minority volunteer donors is small, so that there is an acute need for these particular groups to help save the many minority patients seeking donors.

Unfortunately, our friend's son did not match any of his family members or relatives, so the search is on for caring people to volunteer to be tested as a possible donor.

Bone marrow transplant is simply the replacement of diseased bone marrow cells with cells from a healthy donor. To qualify as a donor, one must be between 18 and 55 years old and have no history of Hepatitis B or C, heart disease, cancer or AIDS.

The process towards becoming a marrow donor is not complicated. The first step is a blood test for HLA (Human Leukocyte Antigen) typing. Once this is completed, the potential donor is listed anonymously on the marrow donor registry.

This process enables the donor's HLA to be matched with other patients needing a bone marrow transplant. If a match is found, the potential donor is notified and a consultation is carried out with the transplant team. With the donor's consent, a thorough history and physical examination is conducted. This is to insure and protect the health of the donor and the patient as well. Following this, the transplant is performed. The marrow is harvested under light anesthesia and the donor usually stays overnight in the hospital. The donor's body will replace its marrow within 3 to 4 weeks.

The reward for the donor's generosity is the satisfaction that one has given a truly priceless gift, the gift of LIFE.

Therefore, I urge everyone to please be a donor. Contact me for more information. ■

Report On MMS House of Delegates Fall Meeting

The Massachusetts Medical Society House of Delegates met on November 18 and 19, 1994 in Burlington, Mass. This was the first interim meeting of the House under the new format. Our members who are novices at this structure were ably guided by those experienced at the national level. The work of the House was in two parts: receipt of reports of ongoing Society activities and the disposition of resolutions (in this meeting about three dozen) using a conference committee format. There were three conference committees meeting on the 18th. Each dealt with ten–twelve resolutions. The committee consists of five or six member physicians and couple of staff people. The Committee receives testimony, pro and con, on each resolution, then meets to recommend an action which can be rejection, adoption, adoption with amendment or forward to the board. The work of the committees is synopsized in a report available the next morning when the House deliberates and makes final disposition of the resolutions.

Reports received included activities of the board and society–update on conflict of interest policy, physician network study, membership (just under 17,000) and audit. Of 34 resolutions one was not adopted because its intent had already been implemented. Four were referred to the Board-usually to coordinate with the ongoing work of committees or with AMA policy–for example recommending the formation of an all payor fund to support education and research, mandatory pre marital HIV testing, development of social action committee and assessment of ethical aspects of some cost containment strategies (is there fee splitting?). Twenty-nine resolutions were adopted as presented or amended. These tended to group into–Public policy categories: helmets with in-line skate rentals, regulation of psychotherapists, development of standards for school health curricula, condemn patenting of surgical procedures.

Organizational issues: special committee status for violence prevention and retired physician ad hoc committees, executive secretary will leave by-laws and be under executive vice-president, define investment in by-laws and be under executive vice-president, define investment in by-laws, chair of finance committee to-be voting member of Board.

Physician/patient issues: uniform insurance form, mandatory use of central credentialling service by managed care plans, mandated patient instruction in common English on insurance plan restrictions, financial disclosure by managed care plans are examples.

The next House meeting is May 1995. Please communicate any issues you may wish discussed to Hampden District Headquarters. ■

Francis D. Horrigan, M.D.
Alternate Executive Delegate
Hampden District Medical Society

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Lonnie Bristow: Medicare Reform: The AMA Position

I welcome this opportunity to exchange our ideas along the front lines of organized medicine.What I would like to do is share a little information of how AMA views what's going on and to share a little of what medicine means to me.

I was a boy growing up in Harlem and at the time my mother was working as an emergency room nurse. When I was 13 years old, it was my job to go to the emergency room at the end of her shift at 11:00 p.m. and walk her home. I got to meet the doctors and nurses my mother was working with and sometimes I would feel the drama of their work. I loved every moment that I could be with them. I even started to love the smell of Lysol. I thought these men and women were true heroes. To this day, I still believe those people had an ability to heal, both in their hands and in their hearts. I wanted to be just like them and eventually I became a physician practicing in Northern California. I feel to become a doctor was the best decision I made in my life. I'm willing to bet most of you feel the same way. But through the years, I have watched medicine struggle with problems that at times have the appearance of being so insurmountable, and it does seem at times, that it's time to throw in the towel. And I'm talking about problems for our patients that have nothing to do with the art and science of medicine. These problems are a red hot issue in the early 1990's, but, have you noticed? – Someone's turned down, the flame. The problems are still here but the heats gone away.

It's natural to wonder what went wrong. And, I think the answer's relatively simple. Washington D.C. let the country down. As a result, there will be no single, sweeping act of health reform legislation like the country expected. There will be no big bang effect, instead there will be a series of little bangs. A badly constructed law would have helped no one. The Congress wants to move forward now with incremental changes and the AMA supports that. Congress will probably begin with modest insurance reform. For example, ending the exclusions for pre-existing conditions, is a change that has very strong support with the middle class voters. The challenge is to find that kind of common ground and soon because, ready or not, here comes the 1996 presidential campaign. The President and Congress will do all that they can to avoid severe budget cuts and tax increases in the year before the next election. That means the big budget action is going to have to take place this year. We're already jabbing and sparring about the tax cuts and no one will win this battle unless there are spending cuts as well. Something's going to have to give and I think that will be Medicare.

> The AMA has a treatment plan for what ails Medicare.

If you heard a giant screeching sound on New Year's Day, that was the sound of a paradigm moving. On that day, the first of the baby boomers became eligible for membership in the AARP. Before we know it, they'll all be racing towards 65. The first thing they're going to ask is "Where is my Medicare?" At the rate we're going, they might not be able to get Medicare unless Medicare is changed definitively. Medicare is complicated, controversial and costly. A generation ago, the LBS Great Society promised our older citizens that government is going to take care of their health care no matter who they are. Today we're financing health care for 36 million elderly and disabled people. It's the closest thing we have to universal health care and it's the country's second biggest entitlement program,

12% of all federal spending and predicted to rise to 18% in 10 years. The program costs $5 billion in 1967, this year it cost $176 billion and that number is expected to double by the year 2000. The government keeps pushing the promise of Medicare without ever coming up with a reliable way to pay for it. Working people through a payroll tax pay for the care of those who are already retired. Right now it requires four workers to pay for each Medicare beneficiary. In just a few years, as the whole population ages, there will be only two workers to pick up the tab. It's up to this generation to make some serious changes in the program now to bring the problem under control. In the past, people have suggested either reducing the level of benefits for all or reducing the number of people eligible until we get down to what we can afford. We believe that instead Medicare needs nothing less than a transformation to turn it around. The fact that, for some services under Medicare, physician fees are only 30% of the reimbursement paid by Blue Cross is only a symptom of a larger problem.

The AMA has a treatment plan for what ails Medicare. It is based on six principles. **First** is to give the people who use Medicare a financial stake in their own care. There is no sense of individual patient responsibility for health care costs. Medi gap insurance doesn't help that tendency at all, because the care appears to be free to patients and you and I know it is not. I believe that if people had in mind all the time what health care services cost, then that excessive demand would have to diminish.

Principal number two is to make the financing of Medicare more equitable. Right now working people who may be near the bottom of the economic ladder are subsidizing health care for some elderly who may be near the top. This is bad fiscal and human policy.

Third we believe you should open up Medicare for price competition. I think older Americans are increasingly sophisticated shoppers for the most part. If given real choices, they will help to bring down excessive costs.

Fourth we need to tear down the regulatory maze that makes Medicare a nightmare. The public may not know it, but Medicare is run by a mish mash of dozens of private intermediaries, with surprising discrepancies in their standards. For example, an older woman is 180 times more likely to be turned down for a mammogram in Southern California than she would be in Northern California. A chest x-ray that would be OK in South Carolina is 500 times more likely to

Continued on next page

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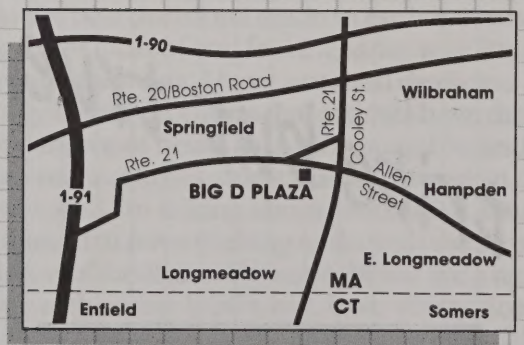

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Medicare Reform

Continued from previous page

be denied in Illinois. The answer is to simplify the system and remove the inequities.

As a **fifth** principle of Medicare, the AMA is going to be calling on you to reduce the level of care that is simply not necessary. The care that is part of defensive medicine is going to be a fact of life until the laws that govern professional liability are revised. We believe at AMA that a significant portion of this problem is educational and that we are uniquely positioned to educate doctors, hospitals, patients and their families regarding the medical and ethical considerations involved in liability questions.

Sixth, we propose to eliminate fraud both inside and outside the medical profession. Billions are being stolen from the Medicare program every year. These precious resources could be utilized where they are needed. Practitioners are billing for services that they never rendered and giving kickbacks for referrals. We as physicians do have an ethical obligation to report fraud. The AMA, and it may come as news, operates a hot line for physicians to report evidence of fraud. We are working closely with the FBI to identify and pursue corrupt persons or entities within the medical community. We're not just providing a refresher course in the age old "Physicians, heal thyself." We are issuing a wake up call. The hot line number is 1-800-AMA-3211. We're encouraging you, if you have concerns about something that's going on, to call that number.

If any transformation of Medicare is going to work, we'd better be at the table this time. Doctors were largely shut out of the process last time, and that is one of the important reasons health care reform didn't get off the ground. There's a whole new era beginning in Washington. And at the AMA we are encouraged that we will be able to sit down with the 104th Congress *and* the President to solve the problems of Medicare. We will tell them doctors are willing to share the sacrifice so long as we are not the only ones sacrificing. We are ready, along with the country's elected representatives, to turn Medicare into a promise delivered instead of a promise betrayed. We are putting a new proposal on the table today. We think it's time to change the system so people who can afford it pay for their own fair share, while making sure that those who can't afford it still get the publically financed health care they need. In other words, provide all the Medicare benefits for some of the people and some of the Medicare benefits for all of the people and reduce the rate of spending at the same time. I believe it can work if the politicians only have the courage to try and implement it.

We have been talking for the most part about

the macroeconomics of medical care. But when we go to the office in the morning, we don't practice macro medicine, we practice one patient at a time. We believe that patients deserve a system that lets doctors focus on them. This is not a brand new idea. Centuries ago, Maimonides, was a physician but also a philosopher, a lawyer, and a scholar. Maimonides wrote a daily devotional that illuminates the ethical duty of the physician. The prayer of Maimonides says: "I am now about to apply myself to the duties of my profession. Inspire me with love in my heart. Do not allow a thirst for profit or ambition for renown or admiration to obscure it, for these are the enemies of truth. In the sufferer, let me see only the human being."

Don't let the men and women who represent us in Washington take the easy way out. Demand that they restructure Medicare. All for some, some for all–a concept that is fair.

Dr. Bristow gave the above address on January 24, 1995 at the winter meeting of the Hampden District Medical Society. A lively discussion followed. Dr. Bristow suggested that unfortunately the 1996 Presidential campaign had already begun. He felt that the well financed Presidential ambitions of Senators Dole and Gramm would prevent their mutual cooperation in formulating legislation. He was optimistic that tort reform might advance. He stated that under the Clinton health plan, a condition of including tort reform was the acceptance of other obnoxious features like price controls.

Dr. Bristow also spoke in favor of health savings accounts as an incentive for individuals to assume responsibility for their health care needs by shifting the tax advantage from the employer to the individual. In the area of further national action on tobacco control, Dr. Bristow said that Congressman Wiley of Virginia's committee will reject any federal effort in this area and that the AMA will not "trade off" the tobacco issue for support in other areas. He feels that long term we have the tobacco issues "on the run", because of public health initiatives on the state level.

Dr. Bristow felt that the differential subsidizing of Medicare based on income should avoid a degrading "means testing" at the doctor's office.

Pictured left to right are Lonnie R. Bristow, M.D., President-Elect of American Medical Association; Alicia O.M. Ross, M.D., President of the Hampden District Medical Society and Francis X. VanHouten, M.D., President of the Massachusetts Medical Society.

One way to apply this differently would be to make Medicare benefits taxable income. Those who didn't have significant income wouldn't end up paying tax on these benefits.

Dr. Bristow feels that further changes to solve the high cost of insurance for working families will have to come incrementally. He expressed frustration at this turn of events. He believes these changes will come initially through insurance reform and will not evolve significantly until beyond the next *two* Presidential administrations. ■

Brigid Glackin, M.D.

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Physician Assisted Suicide And End Of Life Decisions

Professor Arthur James Dyck addressed the tenth anniversary session of the Medico-Religious Committee Forum on October 18, 1994. Professor Dyck is Co-Director of the Kennedy Interfaculty Program on Medical Ethics of the Harvard Divinity School and the Harvard School of Public Health. His remarks are summarized below.

I take it that this is a group that, unlike the stereotype of high level corporate executives, does have a problem with unethical projects. It is also a group that is not afraid to discuss these very difficult issues publically in order to illuminate them.

The hard won consensus that life is sacred has come under fire.

What we are seeing in the past ten years, since I was here at the first lecture of this series, is a pressure in the media for "instant death." And this has come at a time when the level of expertise in medical care is superb. There is an ever increasing sophistication in the area of pain management. Many are living longer today and living a pain-free life than ever before in human history. At the same time, there is an ability to maintain the sustenance of life for individuals who are persistently unable to respond to their environments. So the discussion as to when to stop treatment has become extremely difficult, precisely because of the level of technical expertise which allows us to extend life to an unprecedented degree.

Those developments are only part of the story. The hard won consensus that life is sacred has come under fire. Some see this view as a religious view and contrast it with an individual view that whether I live or die is my decision and no one should interfere with that decision. In addressing this issue, the Canadian Supreme Court has argued that the view that life is sacred has a secular aspect as well. I would argue that no human community can come about and be maintained unless its members wish the self and the other to exist. The procreation, nurturing and protection of individual human life is what makes communal life possible. All morality and law begin there.

What does it mean to die well in our era of high tech medicine? I would argue it means distinguishing between comfort only treatment and killing whether it is killing oneself or being killed. It means rejecting as unethical and unlawful the practice of physician assisted suicide.

Dying well also means rediscovering and redefining a view of physicians and patients which affirms the preciousness of human life.

In 1975, James Rachels argued that there is no ethical difference between killing and allowing to die. He used as his paradigim the example of Smith, who will inherit on the death of his 6 year-old nephew. On the day his nephew slips accidentally and falls unconscious in the shower, Smith holds him under the water until he drowns. Jones, in a similar circumstance, stands aside to see if his nephew will wake up before he drowns but he doesn't find it necessary to hold his nephew under the water. Rachels notes that there is no ethical difference between the behavior of Smith and Jones and he is correct. But Rachels has presented two cases of preventable deaths and two individuals with similar, killing intent. The moral differences between killing and failing to act to extend life do not emerge in the example.

In my own experience, my father developed peritonitis in his 50's and in great pain stated that he wanted to die. I urged him not to give up and demanded that his physician do everything to save my father's life.

This is a case where death is preventable and treating for comfort only not appropriate in that my father lived 30 more years. At that time, my father's voice was considered not his genuine wish because he was in great pain.

Thirty years later, my father returned to the hospital exhausted and uncharacteristically thin.

He was barely able to ask me "Why are they doing this?" We couldn't get any answer from the attending physician so we got another one who read us the chart and answered. "There is no point. There is cancer throughout." Now comfort became the order of the day. One of the most wonderful things about comfort only treatment is that my father had the chance to talk to his granddaughter instead of dying on the operating room table or being too exhausted by tests and treatments to communicate.

Margaret Mead the anthropologist, regarded the separation of killing and healing as a sign of advancement of the civilization. Why should mercy killing be regarded as unethical? There are four reasons. First is that the advocacy for pain relief is undermined or lost. Why should it be lost? If pain can be ended by death, then why persist in the tedious titration of medicine and the proffering of emotional support that often alleviates pain. Secondly, when mercy killing is promoted, the advocacy for life is undermined and lost. Thirdly, the patient's consent is undermined, and finally the treatment of the suicidal depression is undermined.

The argument for assisting with suicide is that the cool, persistent, *rational* request for assistance by the patient should not be denied. That the request is *rational* is what is said to make it *ethical*. This is compounded by the fact that death is the most painless way to end suffering. But the implications are that the physician's advocacy for suicide undermines the patient's consent and that once satisfying the patient's wish is the justification where can the line be drawn as to in which circumstances satisfying that wish is appropriate. A study in the Lancet of Holland's practice of assisted suicide (September, 1991) showed an annual rate of 2300 cases of voluntary euthanasia. However also found were 1100 cases of involuntary suicides. Additionally 4900 cases of intentional morphine overdoses and 8000 instances of stopping treatment to end life without patient consent were documented. 14% of the patients were competent and 45% of families were not informed. How did this happen? I would call these cases of involuntary euthanasia compassion not rightly aimed.

Affirming the preciousness of life is a responsibility of the ethical professional. Refraining from killing symbolizes the preciousness of human life and is a fundamental responsibility. We risk everything by breaking down the separation between killing and healing that modern communities have established. It is hard to stop killing once it starts as history shows us. As Cicely Saunders of the Hospice movement has suggested, "Anything that says to the very ill or the very old that there is no longer anything that matters will lead to a deep impoverishment of the whole society". ■

Transcribed and Edited By
Brigid Glackin, M.D.

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1994 Interim Meeting Of The House of Delegates

by Alan Harvey, M.D.

Introduction

- The AMA House of Delegates met in Honolulu, December 4-7, 1994
- The House considered 190 resolutions and 92 Board and Council reports on topics affecting medical practice and the public health of the American people.
- There were 413 delegates seated, representing every state and virtually every national medical specialty society.

Managed Care and the AMA's Private Sector Initiative

The Board of Trustees presented a 57 page report that described current trends in managed care; summarized risks and opportunities for physicians and patients; and presented a detailed AMA strategy for managed care and the private sector. In addition, there were numerous resolutions submitted calling on the AMA to undertake activities and programs.

The House approved the report, emphasizing the following four principles:

A. Professionalism–Medical Science and Ethics
B. Patient and Physician Autonomy
C. Patient and Physician Rights
D. Practical Assistance to Physicians

The House also adopted a substitute resolution specifically calling on the AMA to undertake or continue the following activities:

1. Support at the federal and state level for the "Patient Protection Act."
2. Identify and publish those cost factors contributing to the escalation of health care costs with particular attention to patient responsibility and administrative costs.
3. Support state and county efforts on behalf of member physicians deselected by managed care plans for other than quality reasons.
4. Investigate and publicize the ways managed care can be involved in education, training, and research.
5. Evaluate the impact of managed care plans or medical care quality and medical ethics, and identify those practices that adversely affect the delivery of quality health care services.

In related actions, the House adopted the following policies on managed care calling on the AMA to:

Financial Incentives: Amend the Patient Protection Act with a provision similar to that in the Medicare law which requires health plans operating a physician incentive plan to meet requirements ensuring that no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement

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to reduce or limit medically necessary services to individual patients.

Post-Operative Services. Managed care plans should not limit or abrogate the surgeon's professional duty to care for the patient until recovered from the operation or other surgical care and the AMA and the national medical specialty societies develop, through the Practice Parameters Partnership and Practice Parameter Forum, guidelines for reasonable lengths of follow up and/or concurrent care by specialist physicians based upon prudent medical care.

Pediatric Subspecialists. Advocate that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties and advocate that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age-group specific.

Board Certification. AMA and national medical specialty societies work together to educate patients, purchasers of health care services, managed care organizations, and other entities about the need to assess the quality of services provided by individual licensed physicians using multiple criteria rather than exclusively by the presence or absence of board certification.

Residents. Encourage managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting and develop model contractual language that graduate medical education programs may use in negotiations with managed care plans that will allow residents under faculty supervision to care for patients in inpatient and outpatient settings.

Medical Consensus. All managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition.

Patient/Physician Decision-Making. Managed care and other physician agreements should not prevent or impede a physician's obligation to provide full disclosure of information to patients to enable informed medical decision-making, and should not prevent a physician from discussing options that would benefit a patient's medical condition and work with national associations representing independent practice associations, health maintenance organizations, and other managed care organizations to develop model contract language to avoid inappropriate restrictions that could intrude upon physician and patient decision making and the patient/physician relationship.

Physician Contracts and Services. Study the potentially conflicting economic and ethical issues involved in managed care contracts, such as bundling physician payments with other costs, use of restricted formularies, profit-dominated exclusive contracts, and access to discounts available for drugs, tests, and services ordered by out-of-network physicians for network patients.

Patient Education. Develop, in conjunction with interested national medical specialty societies, state medical associations, and county medical societies, model educational materials that medical societies may reproduce and distribute to Medicare beneficiaries regarding the available types, costs, and limitations of health care coverage options and delivery systems.

Population Based Practices. Recommend to all managed care plans that they:

1. Develop populations based programs for prevention, health risk assessment, and health status improvements.
2. Adopt a process to measure clinical quality provided to patients and demonstrate how quality in their system of care is improving;
3. Develop programs which assure that communicable and environmentally induced health problems are followed up by physicians within the plan in cooperation with competent health department personnel; and
4. Manage these programs in concert with established standards of preventive medicine and public health.

Health System Reform

The Board of Trustees submitted a report that presented an update on AMA efforts to advance our health system reform policy and goals. It included recommendations and objectives for 1995. The House adopted as amended the following recommendations:

1. That the AMA continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and patient/physician relationship, at the forefront.
2. The the AMA seek an incremental approach to health system reform, targeted by patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, medical savings accounts, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act.
3. That the central focus of AMA's reform campaigns in 1995 be the Patient Protection Act, professional liability reform, insurance reform, Medical Savings Accounts, regulatory reform and physician network/anti-trust relief as the most immediate ways to expand patient choice, improve quality and enhance professionalism.

Continued on next page

1994 Interim Meeting

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4. That the AMA further increase choice and cost consciousness by advocating the development of voluntary purchasing groups, a wide variety of choice plans and, where an employer contributes to health plan costs, a standard dollar contribution toward an employee's insurance irrespective of the plan chosen.
5. That the AMA reaffirm the profession's historic commitment to public health, public service and to providing care to those in need, and that the AMA Councils search for ways to expand access to care consistent with an incremental reform approach.
6. That the AMA fight for adequate funding for federal health care programs, in particular, Medicare and Medicaid; that AMA further advocate for long term reform of those programs which insures their effectiveness and fiscal soundness and against reimbursement reductions which promote cost shifting, diminish access and reduce the quality of care for beneficiaries.
7. That the AMA reaffirm policy which calls on the AMA to continue to develop and implement the State Health System Reform Action Group (SHRAG) initiative to provide meaningful assistance on state health system reform matters upon their request to state medical societies.

Employer Control of Health Insurance Choices

The council on Medical Service reported on a study of ways to discourage control of employee health insurance choices by employers. The Council modified several existing AMA policies into a single, concise statement that was further amended by the House to read as follows:

1. Support the individual's fight to select his/her health insurance plan and support ways in which the concept of individually required and owned health insurance can be integrated, in a complementary position, into the AMA's position on achieving universal coverage and access to health services.
2. Support for individually-owned health insurance as an alternative to or in conjunction with employer-based health insurance.
3. Support for the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased insurance as for employer-purchased coverage.
4. Strong support for legislation promoting the establishment and use of medical savings accounts (MSAs) and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

State Health System Reform

The House approved a substitute resolution asking the AMA to:

1. Continue to work with state medical societies, at their request, on state directed health system reform, to complement our efforts at national health system reform, and
2. Encourage and support federal legislation, at the request of state medical societies, including the necessary ERISA, Medicaid, and other federal waivers, to allow those states to implement health system reform at the state level.

AMA Budget, Fiscal 1995

The House commended the Board of Trustees and the Executive Vice President on the 1995 Plan and Budget. These officials presented new strategic directions for the AMA at the opening of the House and also reported on the new organizational activities designed to address these new directions and the allocation of resources needed to achieve these ambitious goals. Consolidated Operating Revenues are budgeted at $199.0 million and consolidated operating expenses, including income taxes, at $196.8 million, leaving the AMA with budgeted revenues in excess of expenses of $2.2 million.

Antibiotic Usage of Bacterial Resistance

The House adopted a policy calling for a study of the necessity of developing educational materials for patients and the general public that will:

1. Encourage appropriate antibiotic use
2. Foster an understanding of the relationship between antibiotic use and the development of antibiotic-resistant bacteria.

Control of Ecoli Infection

The House adopted a substitute resolution that responds to recent outbreaks of food poisoning due to Ecoli infection. The resolution asks the AMA to urge physicians to:

1. Familiarize themselves with infection due to Ecoli 015:H7

Continued on next page

1994 Interim Meeting

Continued from previous page

2. Regularly request culture for this organism in any study of infection associated with bloody diarrhea stools
3. Expand efforts to educate consumers, food processors, and food handlers about the general importance of proper food handling and preparation
4. Urge adoption of reporting Ecoli 0157:H7

The resolution also asked the AMA to encourage and support the continuing efforts of the FDA and the Department of Agriculture to develop new and improved methods and technologies for reducing or eliminating bacterial contamination of meat and meat products for human consumption.

Weekly Reader Influence On Children's Attitudes About Smoking

Considerable testimony was presented at the Reference Committee's hearing expressing great dismay over the *Weekly Reader's* biased and unbalanced presentation on smoking to children. The House adopted as amended a resolution that calls on the AMA to:

1. Express strong objection to the *Weekly Reader* about the extensive coverage of smokers' rights information without accompanying information on the adverse effects of tobacco use on the health of children and adults and urge the editors to include such information in future issues.
2. Express strong concerns that the ownership of K-111 Communications may be exerting an inappropriate influence on the content of the *Weekly Reader* and destroying the reputation that the publication has had over many decades for unbiased educational reporting to elementary children.

Conclusion

Time prevents me from commenting on everything that was considered by the House of Delegates.

Meetings of the AMA House of Delegates are open to every member and are conducted in a most democratic manner. They provide those who attend a unique educational experience as a wealth of information is disseminated and discussed. Members may present testimony at the Reference Committee hearings and there are many other opportunities to get your views across.

If you cannot come to the meetings, let your delegation know your opinions and concerns.

Many AMA policies and programs began with an individual physician who had a good idea and coaxed it through the democratic process.

I will be happy to respond to any questions. ■

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The Life And Times Of The Ludlow Hospital 1908-1994

The physicians of Hampden County sadly note the demise of the Ludlow Hospital. The hospital closed its doors to inpatients in December, 1994. All of our local hospitals, which are all private non-profit entities, have, at various times in the past ten years, been the subject of rumors about their financial instability. Still this actual closure seemed at once inevitable and unbelievable. A review of the history of the hospital is offered in order to chronicle its evolution in changing times.

The Hospital closed its doors to inpatients in December, 1994.

The town of Ludlow doubled its population from 1875 to 1900 as it evolved into a one company milltown which supplied work to an influx of immigrants. The principal employer of the town was the Ludlow Manufacturing Associates. The company viewed its employees in a paternalistic way and built housing, schools, parks and street improvements for their town. In this spirit, the Ludlow Manufacturing Associates decided in 1908 to build a hospital for Ludlow. A meeting of citizens was held April 28, 1908 to form the Ludlow Hospital Society. The Ludlow Manufacturing Associates gave to the society a newly constructed hospital building with equipment free of rent and agreed to supply heat from its steam manufacturing plant. The company also offered to subsidize the hospital with matching funds for contributions or membership fees the Society collected.

Dr. James W. Hannum, a Columbia University Medical School Graduate, had come to Ludlow to practice in 1879. He was elected the first president of the Ludlow Hospital Society. Other officers and committee chairs were prominent committee members including managers from the Company. These officers formed an executive committee to manage the affairs of the hospital.

The hospital opened for business July 3, 1908. The first "superintendent' was Miss Emma Glover from Waltham. Dr. Hannum was head physician and he was assisted by Dr. A.J. Treichler of Ludlow and Dr. Fred LaRochelle of Springfield. Early benefactors were Annie and M. Louise Stebbins and Mrs. Thornton Parker who donated funds to equip the operating room and for an x-ray machine in honor of their father who was a former president of the Ludlow Company. Admissions rose steadily: there were 41 the first year, then 85 in 1909 and 170 in 1910.

The financing of the society was determined by the Hospital Society bylaws. By 1909, membership fees had risen to three dollars per year, payable at one time or in monthly installments of twenty-five cents. Typical factory employees were paid six dollars weekly at this time. The Society's bylaws gave preference in hospital admission to society members, whether or not they were Ludlow Manufacturing Associates employees and despite the Company's subsidy. Members were required to pay any unpaid balance on dues prior to hospital admission.

This early Hampden County "group insurance plan" entitled the membership to free hospital care including the services of a physician of the individual's choice and surgical attention for any illness "provided it was a suitable one for hospital care." Services not covered by membership dues included maternity care and treatment of contagious and incurable diseases. Patients with these excluded conditions and all non-members paid seven dollars a week for care. Private rooms and private duty nursing were paid separately. Children under 14 were eligible for two weeks of free care if both parents were members and one week if only one parent belonged to the society. Non-members were admitted only if there was

room in the hospital.

The Ludlow Company continued its cash subsidy to the hospital for the first five years of its operation. By 1914, the hospital was financially successful and applied to the state to form a corporation. George A. Birnie, a high level manager with Ludlow Manufacturing Associates, was the first president. The statement of purpose for the new organization was to assist in the care of the sick people of Ludlow, to train young women as nurses and to ensure a supply of nurses for the town and to promote sanitary conditions of living.

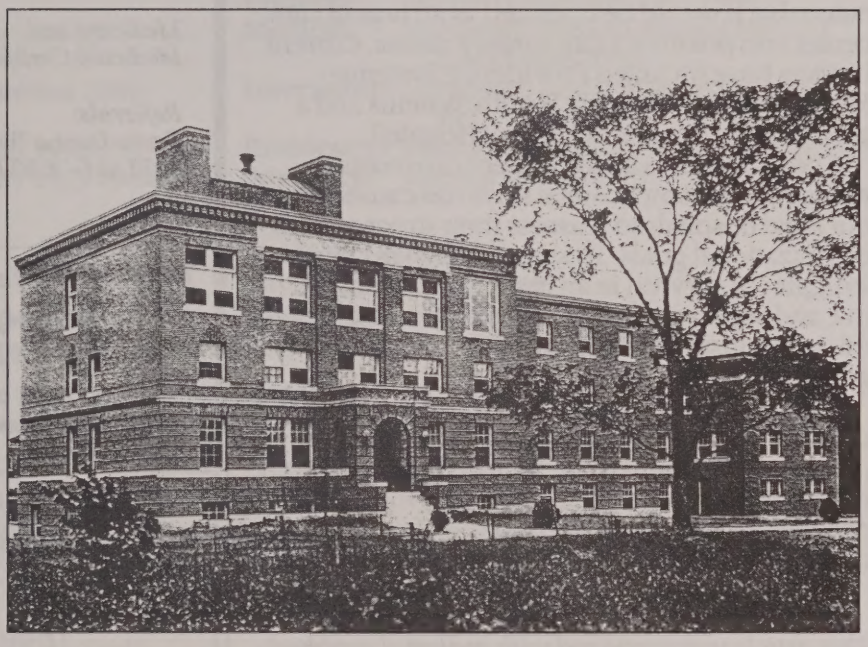
The preparation of new bylaws was the occasion for ceasing the practice of providing free medical care to society members. A clause in the original agreement with Ludlow Manufacturing Associates stated that if the building ever ceased to be used as a hospital it would revert to the company. This clause was cancelled by the company in 1957 at a time when the company was essentially defunct in Ludlow.

The hospital struggled to survive during the Great Depression in the 1930's. The Ludlow Manufacturing Associates was financially unstable and behind in its tax contributions to the town. At one point the board of trustees voted to close the hospital. Funds were raised by townspeople and hospital staff to keep the hospital going. Then the town itself, despite its own financial problems, subsidized the hospital with a $2,500 annual contribution. This practice of town government subsidy to the hospital continued for the next twenty years.

The hospital's next period of crisis began in 1952 when the Massachusetts Public Health authorities threatened to close the hospital because its narrow corridors and frame did not meet fire safety standards. By 1955, the board of trustees decided it would be more feasible to build a new hospital than to modernize. Plans were made for a new structure to be named the Suburban Memorial Hospital. This was to be situated at some central point in the Ludlow–Indian Orchard–Wilbraham area. A fund drive was launched and by 1957 more than $200,000 of a $300,000 goal had been pledged by the public.

Public opposition arose when the hospital site chosen by the board of trustees was not in Ludlow. In August, 1957, a well organized group of opponents joined the society en masse and passed a new bylaw expanding the hospital board by 24 trustees. The newly elected additional trustees all opposed the relocation of the hospital from Ludlow. The two most prominent persons involved in the fight were Walter Moore, then town moderator and Armand Couture, a subsequent hospital administrator.

With the redefinition of the new hospital a new fund drive was required and undertaken. A fireproof 75 bed hospital was constructed next to the old building at a complete cost of $871,000. This new building opened in February, 1962. The hospital expanded this building with funds obtained from the Hill-Burton Act during the 1960's. Another benefactor was the widow of Dr. Norman Jonas who donated his library and equipment to the hospital in 1968. The original building from 1908 was demolished in 1974. It was replaced by the Richard J. Sackett Memorial Wing which contained a new coronary care unit, a central laboratory and a new emergency treatment center. The hospital had closed their maternity unit in 1966 as recommended by the Massachusetts Department of Health due to a low (30%) occupancy rate and the availability of specialized maternity services in Springfield.



The Village Hospital, Built 1908. Built by the Ludlow Manufacturing Associates, and given rent free to the Ludlow Hospital Society.

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Ludlow Hospital

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At the time of its closure, the Ludlow Hospital had a medical staff of 128 of which 28 were active staff, 44 were courtesy staff and 54 were consultant staff. Dr. Mark Goldman was medical staff president. Other officers were Dr. Ralph Otto, vice president; Dr. David Licht, secretary-treasurer; Dr. Harvey Grant, member-at-large and Dr. Sante Caldarola, chief of surgery.

Mary Vaz is president of the board of trustees and Paul Della Rocco the chief managing officer is functioning as spokesman for the board. In January, 1995, the board voted to pursue Chapter 7 bankruptcy and to sell the hospital with expectation that it would be operated as an urgent care center and possibly a day surgery center. Current bidders have included Providence Systems-Mercy Hospital, Baystate Health Systems and a group called Friends of Ludlow Hospital.

The focus on reducing patient care costs by reducing inpatient hospital stays has caused all our local hospitals to reassess their structure and organizational goals. To some physicians this struggle for survival in an increasingly competitive and sophisticated business environment may cause our institutions to lose sight of their true goals.

The Ludlow has, it seems, always served a community which identified and supported its purposes. It remains to be seen, as the community feels the impact of the institution's loss, what portion of the institution's past role if any the community is willing to promote and support. ■

Brigid Glackin, M.D.

This article was prepared with material supplied by Edwin Thorn, CEO of Ludlow Hospital and from "A History of Ludlow 1774-1974, Hert L. McChesney, 1978". Additional source: from "Ludlow Hospital" by Frances Gagnon, Springfield Journal, January 5, 1995.

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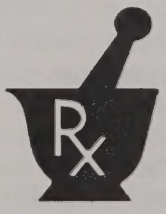

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Brian B. Guarnotta, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 26, 1964
Premed: University of Massachusetts 1982-1988
Medical: University of South Carolina 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Pediatrics
Resident

Markandu Ketheeswaran, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 21, 1959
Premed: St. John's College, Sri Lanka 1973-1979
Medical: Colombo Medical College, Ragama, Sri Lanka 1981-1988
St. George University School of Medicine, Grenada 1990-1991
Residency: Coney Island Hospital, New York 1991-1994
Fellowship Baystate Medical Center 1994-Present
Specialty: Hematology/Oncology
Fellow

John B. McCahan, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 10, 1966
Premed: Cornell University, New York 1984-1988
Medical: University of Massachusetts Medical School 1989-1993
Internship: Baystate Medical Center 1993-1994
Residency: Baystate Medical Center 1994-Present
Specialty: Internal Medicine/Pediatrics
Resident

Richard A. Shuman, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: March 31, 1964
Premed: Harvard University 1982-1986
Medical: University of Massachusetts Medical School 1986-1990
Internship: Dartmouth Medical Center, NH 1990-1991
Residency: Dartmouth Medical Center 1991-1993
Specialty: Internal Medicine

James J. O'Brien, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 13, 1960
Premed: St. Michael's College, Vermont 1978-1982
Medical: Royal College of Surgeons, Ireland 1983-1988
Internship: St. Vincent's Hospital, New York 1988-1989
Residency: St. Vincent's Hospital, New York 1989-1991
Chief Residency 1991-1992
Fellowship: Baystate Medical Center 1992-1995
Specialty: Internal Medicine/Cardiology
Fellow

Jennifer L. Sabol, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 3, 1964
Premed: Franklin & Marshall College, PA 1982-1986
Medical: Jefferson Medical College, PA 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-Present
Specialty: General Surgery
Resident

Continued on next page

New Members Welcome

Continued from previous page

Shelley B. Rahn, M.D.
Massachusetts Mutual Life Insurance
1295 State Street
Springfield, MA 01111

Born: April 12, 1955
Premed: Cornell University 1973-1977
Medical: State University of New York, Buffalo 1977-1981
Internship: Bronx Municipal/Einstein College Hospital 1981-1982
Residency: Bronx Municipal/Einstein College Hospital 1982-1984
Fellowship New York Medical College 1984-1986 (Gastroenterology)
Specialty: Internal Medicine/Gastroenterology/ Administrative

Peter J. Buckley
37 Wilcox Street
Springfield, MA 01105

Born: April 16, 1961
Premed: University of Massachusetts 1989
Medical: University of New England College of Osteopathic Medicine 1996

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